UNITED STATES BANKRUPTCY COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

In re:	Bankruptcy Case No. 13-53846
City of Detroit, Michigan,	Honorable Thomas J. Tucker
Debtor.	Chapter 9

CITY OF DETROIT'S CITATIONS TO BCBSM AND HAP COVERAGE CERTIFICATES SUBMITTED IN ACCORDANCE WITH THIS COURT'S MAY 29, 2015 ORDER [DE 9901] REGARDING FURTHER PROCEEDINGS ON THE CITY OF DETROIT'S MOTION FOR CERTAIN RELIEF AGAINST THE DPLSA

Pursuant to the Court's May 29, 2015 Order, the City submits that the following citations from the HAP and BCBSM coverage certificates [DE 9974 and 9976] support the City's pending motion.

1. **BCBSM coverage certificate – relevant pages appended as exhibit 1**.

The first two paragraphs on page 2 of the BCBSM Benefits Certificate states as follows under the heading "Eligibility," and subheading "Who is Eligible to Receive Benefits:"

> "You, your spouse * * *and your children listed on your contract are eligible. You will need to receive an application for coverage.
>
> "BCBSM will review your application for coverage to determine if you, your spouse and your dependents are eligible for coverage. This determination is based on the terms of your benefit plan, which include this certificate and any underwriting policies that are in effect at the time of your application."

See also the definition of "Group" at page 143 and the definition of "Spouse" at page 158.

2. HAP coverage certificate – relevant pages appended as exhibit 2.

Page 2 of the HAP Subscriber Contract, section 2 (Eligibility), paragraph 2.2 (Dependents), states:

> "The following persons are eligible for coverage as the Subscriber's Dependents under this Contract if they meet the eligibility requirements of HAP and the Group:
>
> "a. The Subscriber's legally married spouse."

See also the definitions of "Dependent," "Eligibility" and "Group" at pages 39 - 40.

June 23, 2015

Respectfully submitted,

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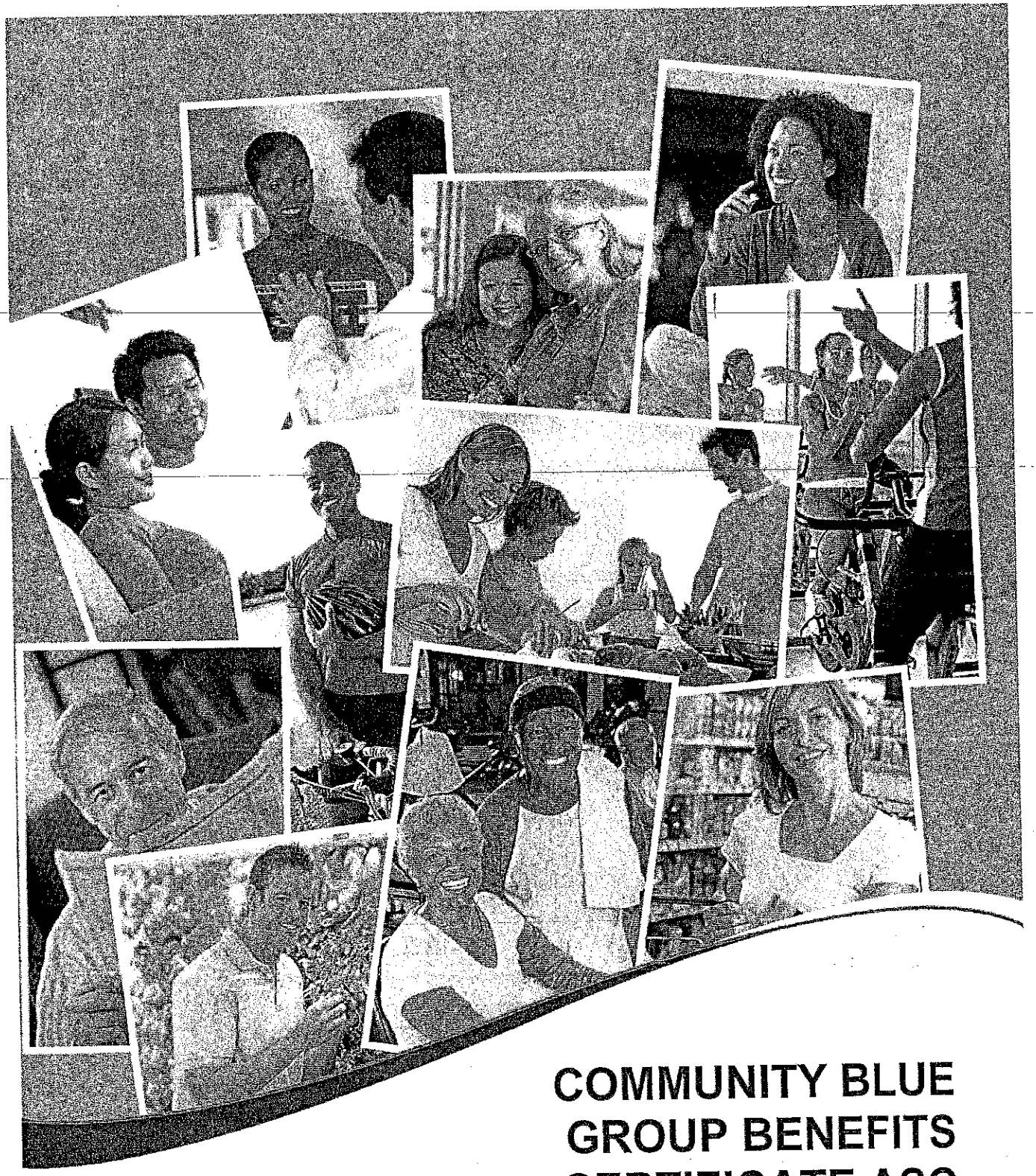
ATTORNEYS FOR THE CITY OF DETROIT

EXIHBIT 1



COMMUNITY BLUE GROUP BENEFITS CERTIFICATE ASC

(Available to ASC Accounts Only)

Ex. 1

ELIGIBILITY

Who is Eligible to Receive Benefits

You, your spouse (this does not include a person who marries a member who has coverage as a surviving spouse) and your children listed on your contract are eligible. You will need to complete an application for coverage.

BCBSM will review your application for coverage to determine if you, your spouse and your dependents are eligible for coverage. This determination is based upon the terms of your benefit plan, which include this certificate and any underwriting policies that are in effect at the time of your application.

If you, your group or someone applying for coverage on your behalf commits fraud or makes an intentional misrepresentation of material fact in completing the application, your coverage may be rescinded as described on Page 6, under "Rescission."

Children are covered through the end of the calendar year in which they turn 26 years of age if, and as long as, the subscriber continues to be covered under this certificate and the children are related to you by birth, marriage, legal adoption or legal guardianship.

Your child's spouse and your grandchildren are not covered under this certificate.

Disabled, unmarried children may remain on your contract beyond the end of the calendar year in which they turn age 26 if all of the following apply:

- They are diagnosed as totally and permanently disabled due to a physical disability or developmental disability and are incapable of supporting themselves.
- They are dependent on you for support and maintenance.

Physician certification, verifying the child's physical disability or developmental disability must be submitted to us no later than 31 days after the end of the calendar year in which the child turns age 26. The information will be evaluated to determine if the dependent meets this definition.

You may also request group coverage for yourself or your dependents within 60 days of the following event:

- Your Medicaid coverage or your dependents' CHIP coverage (Children's Health Insurance Program) is terminated due to loss of eligibility.

Group
A collection of subscribers under one contract. Generally, all members of a group are employed by the same employer. One employer, however, may have different segments or categories of employees working for the same employer. A group can also include participants of a trust fund that has been established to purchase health care coverage pursuant to collective bargaining agreements.

Gynecological Examination
A history and physical examination of the female genital tract.

Hazardous Medical Condition
The dangerous state of health of a patient who is at risk for loss, harm, injury or death.

Health Maintenance Examination
A comprehensive history and physical examination including blood pressure measurement, skin examination for malignancy, breast examination, testicular examination, rectal examination and health counseling regarding potential risk factors.

Hematopoietic Transplant
A transplant of bone marrow, peripheral blood stem cells or umbilical cord blood.

Hemodialysis
The use of a machine to clean wastes from the blood after the kidneys have failed.

High-Dose Chemotherapy
A procedure in which patients are given cell destroying drugs in doses higher than those used in conventional therapy. Stem cell replacement is required after high-dose chemotherapy is given.

High-Risk Patient
An individual who has an increased risk of mortality or morbidity according to standard criteria recognized by the oncology community.

HLA Genetic Markers
Specific chemical groupings that are part of many body cells, including white blood cells. Called human leukocyte antigens, these chemical groupings are inherited from each parent and are used to detect the constitutional similarity of one person to another. Close (or the degree of) identity is determined by tests using serologic (test tube) methods and/or molecular (DNA fingerprinting) techniques. An HLA identical match occurs when the six clinically important markers of the donor are identical to those of the patient.

Home Health Care Agency
An organization that is primarily engaged in providing skilled nursing services and other therapeutic services in the patient's home.

Hospice
A public agency, private organization or subdivision of either, which primarily provides care for terminally ill persons.

Specialty Pharmaceuticals
Biotech drugs, including high-cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include vaccines and chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin. **Select specialty pharmaceuticals require preauthorization from BCBSM.**

Examples of specialty pharmaceuticals include, but are not limited to, the following:

- Drugs administered by infusion therapy providers
- Drugs administered in the office by health care practitioners
- Certain drugs to treat highly complex disorders, such as multiple sclerosis, lupus and immune deficiency
- Chemotherapy specialty pharmaceuticals dispensed at the pharmacy and self-administered, or administered by a health care practitioner at an approved facility or a physician's office

BCBSM will cover these drugs under the certificate that applies to the benefit. For example, drugs administered in the office by a health care practitioner are covered under the certificate that applies to your medical benefits.

Specialty Pharmacy
Companies that specialize in specialty pharmaceuticals and the associated clinical management support.

Speech and Language Pathology Services
Rehabilitative services that use specific activities or methods to treat speech, language or voice impairment due to an illness, injury or following surgery.

Spouse
An individual who is legally married to the subscriber and meets the group's eligibility requirements.

Stabilize
Stabilize, with respect to an emergency medical condition, means that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the patient from a facility (or with respect to a woman who is having contractions, to deliver the child (including the placenta)).

Stem Cells
Primitive blood cells originating in the marrow, but also found in small quantities in the blood. These cells develop into mature blood components including red cells, white cells and platelets.

EXHIBIT 2

HMO

Health Maintenance Organization

Health Alliance Plan of Michigan

Subscriber Contract

Health Alliance Plan of Michigan (HAP) hereby certifies that individuals eligible for insurance are insured under the above Contract as determined by the provisions contained in Section 2 of this Contract. The Contract details the benefits and terms of coverage. You are entitled to the benefits described in the Contract in exchange for the Premium paid to HAP.

The benefits available under this Policy will be administered consistent with the requirements of state and federal law, including but not limited to the Affordable Care Act (ACA), as such provisions may be implemented over time in accordance with the legislation. Groups that qualify as grandfathered as that term is defined in ACA may be eligible for a different Schedule of Benefits than non-grandfathered groups. Groups shall self-identify as a grandfathered group, if such status applies

James Connelly
President and CEO, Health Alliance Plan
Executive Vice President, Henry Ford Health System

HEALTH ALLIANCE PLAN

HMO SUBSCRIBER CONTRACT

SECTION 1—INTRODUCTION

1.1 Your Coverage

You and your eligible Dependents are entitled to receive the benefits described in this Contract pursuant to an agreement between your Group and HAP. You may also have Riders and a Schedule of Benefits. Your Riders and Schedule of Benefits change the benefits and Eligibility rules described in this Contract. You should keep this Contract, Riders and Schedule of Benefits with your other important papers so that they are available for your future reference.

1.2 HMO Coverage

This Contract provides coverage through Health Alliance Plan (HAP), a nonprofit corporation licensed by the State of Michigan as a Health Maintenance Organization (HMO). Because HAP is an HMO, the services covered under this Contract must be provided, arranged or authorized in advance by your Personal Care Physician (PCP). Your PCP is an Affiliated Provider that you choose who is primarily responsible for providing or arranging for health care services for you. In some cases, your PCP will also need to have services approved by us. Because your PCP is the key to receiving services under this Contract, make an appointment to see your PCP soon. It is also important to read this Contract carefully before you need services.

1.3 This Contract

This Contract is an agreement between HAP and persons who have enrolled as Members. It contains important information about your coverage. You should read this Contract carefully before you need services. By enrolling in HAP and accepting this Contract, you agree to abide by this Contract and recognize that HAP is responsible for arranging, paying or reimbursing for only those services and benefits that are Covered Services under this Contract, subject to all exclusions and limitations set forth herein.

1.4 Definitions

Throughout this Contract, Health Alliance Plan is referred to as "we", "us", "our" or "HAP". The words "you", "your", "yours" or "Member" refer to the Subscriber and/or any Dependents covered under this Contract. There are other words, phrases, and commonly used definitions of health coverage and medical terminology used in this Contract that have meanings unique to health care. If there is a conflict between the terms of this Contract and commonly used terms, the terms of this Contract will govern. The words and phrases used in this Contract are defined in Section 11.

SECTION 2—ELIGIBILITY

2.1 Subscriber

You are eligible for coverage as a Subscriber under this Contract if:

a. You meet the Eligibility requirements of HAP and your Group; and

b. You live or work in HAP's Service Area.

2.2 Dependents

The following persons are eligible for coverage as the Subscriber's Dependents under this Contract if they meet the Eligibility requirements of HAP and the Group:

a. The Subscriber's legally married spouse.

b. The Subscriber's children, by birth or legal adoption who are under the age of 26.

c. The children of the Subscriber's spouse, by birth or legal adoption who are under the age of 26.

d. A Subscriber's child who is recognized under a Qualified Medical Child Support Order. A copy of the court order or divorce decree is required to enroll the child.

If this Contract is considered a grandfathered plan as defined in the Affordable Care Act (ACA), adult children of the Subscriber or the Subscriber's spouse are not eligible as a Dependent under this Contract if the adult child is eligible to enroll in an eligible employer-sponsored group health plan other than a group health plan of a parent. This restriction only applies to Benefit Periods beginning before January 1, 2014.

2.3 Coverage Period for a Dependent Child

a. A child born to a Subscriber or Subscriber's spouse is automatically eligible to become insured as a Dependent. The Effective Date of Coverage will be the date of birth. Coverage will be to the same extent as provided for other Dependent children. Such coverage includes Covered Services for:

1) Diagnosed Congenital Defects.

2) Birth abnormalities.

3) Prematurity.

4) Routine nursery care.

5) Routine well-baby care while hospitalized.

b. Eligibility for coverage for a child by legal adoption begins on the day of placement for adoption. Placement means the day on which the Subscriber or the Subscriber's spouse assumes and retains the legal obligation for total or partial support of the child in anticipation of adoption of the child.

c. Eligibility for coverage for a child who is your Dependent ends on the earliest of the following:

1) The last day of the calendar year in which the child reaches the age of 26, or

2) The date the child becomes eligible for an employer-sponsored group health plan other than a group health plan of a parent. This only applies to Benefit Periods beginning before January 1, 2014.

6) Electrolysis.

7) Abdominal skin flap reduction (tummy tuck).

8) Skin tag or keloid removal or modification.

9) Breast implants, except as specified in Section 4.14.

10) Collagen or Botox injections, unless Medically Necessary.

11) Dermabrasion or chemobrasion.

12) Surgery to upper and/or lower eyelids such as blepharoplasty.

11.14. **Covered Services** means preventive services and the Medically Necessary diagnostic and treatment services described in Section 4 of this Contract, when approved and provided in accordance with this Contract.

11.15. **Custodial Care** means supportive, domiciliary care or basic care including Physician services and other ancillary services in a residential, institutional, or other setting or DME provided in such settings which is primarily for the purpose of meeting the patient's personal needs and which could be provided by persons without professional skills or training. Examples of Custodial Care include, but are not limited to, assistance with the activities of daily living such as bathing, dressing, eating, walking, getting in and out of bed, taking medication, housecleaning and maintenance of the house.

11.16. **Deductible** means the dollar amount that must be met with charges for Covered Services before payment of benefits begins. The Deductible applies to each insured Member and it must be met each Benefit Period. Copayments are not applied to the Deductibles. The Deductibles are shown in Rider(s) and/or in the Schedule of Benefits.

a. **Individual Deductible**

This is the dollar amount of charges for Covered Services each Member pays each Benefit Period. Charges for Covered Services are applied toward the Deductible for each Member individually. Once a Member's individual Deductible has been met, benefits are payable for that Member only.

b. **Family Deductible**

This is the combined dollar amount of charges for Covered Services all Members must pay each Benefit Period. Charges for Covered Services are applied toward the individual Deductibles until the family Deductible has been met. Once the family Deductible has been met benefits are payable for all Members.

11.17. **Dependent** means a Subscriber's family member who satisfies the Eligibility requirements contained in Section 2 of this Contract

11.18. **Effective Date**. means the day on which the Subscriber or Dependent is entitled to receive Covered Services under this Contract as determined by HAP.

11.19. **Eligibility** means the provisions contained in Section 2 of this Contract that state requirements employees must satisfy to become covered Subscribers with respect to themselves and their Dependents.

11.20. **Emergency or Emergency Medical Condition** means a medical condition that starts suddenly and includes signs and symptoms so severe, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to your health or to a pregnancy in the case of a pregnant woman, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part. Emergency services are Medically Necessary services

provided to diagnose, treat and stabilize an Emergency Medical Condition. Emergency services end when your Emergency Medical Condition is stabilized.

11.21. Experimental and Investigative–means any medication, treatment, device, procedure, service or benefit that is experimental or investigational.

a. A medication, treatment, device, procedure, service or benefit may be considered experimental or investigational by HAP if it meets any one of the following criteria:

1) It cannot be lawfully marketed without the approval of the FDA and such approval has not been granted at the time of its use or proposed use.

2) It is the subject of a current investigational new medication or new device application on file with the FDA.

3) It is being provided pursuant to a written protocol that describes, among its objectives, determinations of safety, effectiveness and effectiveness in comparison to conventional alternatives or toxicity.

4) It is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board as required and defined by federal regulations, particularly those of the FDA or the Department of Health and Human Services.

5) The predominant opinion among experts as expressed in the published authoritative literature is that usage should be substantially confined to research settings.

6) The predominant opinion among experts as expressed in the published authoritative literature is that further research is necessary in order to define safety, toxicity, efficacy or efficacy in comparison to conventional alternatives.

7) It is not investigational in itself pursuant to any of the foregoing criteria and would not be Medically Necessary but for the provision of a medication, device, treatment, or procedure that is investigational or experimental.

11.22. **Grievance** means a complaint by a Member (or submitted on behalf of a Member by the Member's representative) concerning any of the following:

a. The availability, delivery or quality of health care services, including a complaint regarding an Adverse Benefit Determination made pursuant to utilization review.

b. Benefits or claims payment, handling, or reimbursement for health care services.

c. Matters pertaining to the contractual relationship between a Member and HAP.

11.23. **Group** means the employer, association or other entity that has contracted with HAP on behalf of its employees, retirees, or Members and their Dependents for Covered Services.

11.24. **Health Maintenance Organization** means an entity licensed by the State of Michigan that provides coverage for health care services that are Preventive Services and/or Medically Necessary, subject to the terms of a Subscriber's Contract, in exchange for a fixed prepaid sum or per capita prepayment.

11.25. **Home Health Care** means alternate skilled care provided in a home environment. Home Health Care must be ordered by an Affiliated Physician and be part of a formal treatment plan filed with and approved by HAP before the first day of care. HAP has the right to request a new treatment plan and written confirmation from the Physician of the Medical Necessity for continued Home Health Care

11.26. **Hospice** means a facility that: